Please send completed form to:
Admissions - CooperRiis
101 Healing Farm Lane
Mill Spring, NC 28756
828-894-7140 Phone / 828-894-7111 Fax
Call or email admissions@cooperriis.org with any questions.
Additional forms at wwww.CooperRiis.org

Referral for Residency from the Applicant's Treatment Team

Applicant's Name ____
Address ________________________________ City ______________________ State______ Zip__________

Male o   Female o   Marital Status ______________   Date of Birth _____/_____/_____

Applicant's Parent(s), Guardian(s), or Spouse: ***(Please circle one)***

Address ____

City _________________________________ State _________ Zip __________

Cell Phone ___________________________ Home Phone ___________________________

If the applicant has a preference between CooperRiis' two campuses, please indicate that below.

Rural – Mill Spring □   Urban - Asheville □   Is the applicant open to either campus?   **Yes □**   **No □**

I. Psychiatric Profile. Please attach all relevant records, psycho-social summaries and discharge summaries. Please also have the applicant sign and send authorization forms to relevant agencies/hospitals, asking that they send care summaries to us. *(The applicant's physician must fill out this section.)*

Applicant's Diagnosis:

____________________________________   _________________________________

____________________________________   _________________________________

Please submit a detailed, current psychiatric evaluation and prognosis, along with an overview of the applicant's psychiatric, social, educational and work history.

What is your **Assessment** about whether or not the applicant is currently at risk of suicide or inclined in any way to be destructive or abusive toward him or herself or others? Be specific as well about the history of such behavior.

Is the applicant able to be responsible for his/her own behavior and safety in an open rural and/or urban environment, able to care for his/her personal hygiene, able and motivated to participate in the CooperRiis program, able to refrain completely from the use of alcohol and illegal drugs, able to confine cigarette smoking to designated areas, able to function relatively independently without close supervision?

Yes □   **No □**   ***If the answer is no, please fully explain why on a separate page and attach with this form.***

II. Current Medications: The applicant must arrive with at least a two week supply of all current medications. The medications will be dispensed based on this form. If there are ANY changes before the exploratory visit, please update us with a current medications list at the time of the visit.

Medication	Dose	Time Taken	Reason Prescribed

Any PRN medications and for what target symptoms:

Medication	Dose	Time Taken	Reason Prescribed

Previously unsuccessful medications? ____

Is the applicant treatment adherent? If no, explain ____

____

Complementary Care for the Resident. CooperRiis' program is comprehensive. In addition to providing psychiatric services, psycho-education, community work and service, and a therapeutic milieu, we incorporate nutritional and dietary planning, access to massage therapy and other modalities, smoking cessation and physical exercise programming into the resident's personal recovery plan.

Your suggested length of stay for the applicant? ____

Clinician Signature: ____ (Attests to Section II and III)

Printed Name ____ Date __________________________

Address: __________________________________ City/State/ZIP __________________________________

Phone _______________________________ Email ____

Treatment Team Contact Person: ____

Phone _______________________________ Email ____

PLEASE SEND AT LEAST A TWO WEEK'S SUPPLY OF ALL CURRENT MEDICATIONS

06/16